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NEW YORK MEDICAL COLLEGE

A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

School of Medicine

40 SUNSHINE COTTAGE ROAD VALHALLA, NEW YORK 10595 TEL 914-594-4523 FAX 914-594-4565 FACULTY_RECORDS @NYMC.EDU

OFFICE OF FACULTY RECORDS

RECOMMENDATION FOR NYMC FACULTY APPOINTMENT/PROMOTION

SECTION I – TO BE COMPLETED BY PROPOSED FACULTY MEMBER

PERSONAL INFORMATION:

Name Amro (First) (Middle) All (Last)

Soc. Sec. # [redacted] Date of Birth : 08 /01/1971 (Mo) (Day) (Yr)

Preferred Mailing Address for College Business? (*Please check*) ☒ Home ☐ Work

Home Address 7 hegeman Ave, apartment 20 D ,Brooklyn NY 11212

Work Address 180 Varick street, New York, NY 10014

Preferred Telephone Number for College Business? (*Please check*) ☐Home ☐Work ☒Cell ☐Other

Home Telephone (347)405-6258 Home Fax ( ) -

Work Telephone (212)263-2161- Work Fax ( ) -

Cell Telephone (347-623-5406) Other Telephone ( ) -

Preferred E-Mail Address for College Business? (*Please check*) ☐ NYMC ☒ Other

NYMC E-Mail Address

Other E-Mail Address amromd@hotmail.com

Please ☐ Include ☐ Exclude my Other E-Mail address from "Faculty Interactive" group postings.

Gender ☐ Male ☐ Female

Ethnicity
- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black, not of Hispanic origin
- ☒ White, not of Hispanic origin
- ☐ Mexican American or Chicano (Hispanic)
- ☐ Puerto Rican (Hispanic)
- ☐ Other Hispanic
- ☐ Do not wish to respond

Current Citizenship ☐ [illegible]lien ☐ Non-Resident Visa (Visa Type_____)

DEFENDANT'S EXHIBIT F

Name: Amro Ali

EDUCATIONAL INFORMATION:

Undergraduate School: N/A please sees CV

Degree _____ *Year of Graduation* _____

Graduate School/A please see CV

Degree M _____ *Year of Graduation* _____

Honors/Awards _____

Medical School Alexandria University school of Medicine -Egypt

Degree MD *Year of Graduation* 1994

Honors/Awards _____

Residency Training

Specialty Ophthalmology *Dates* 1998-2002

Sponsor _____

Specialty _____ *Dates* _____

Sponsor _____

Fellowship Training

Specialty Neuro-ophthalmology *Dates* 2002-2003

Sponsor Henry Ford Hospital ,MI, USA

Specialty Medical Retinal Diseases *Dates*2003-2004

Sponsor Henry Ford Hospital, MI, USA

Specialty Uveitis and Ocular Inflammatory Diseases *Dates*2007-2009

Sponsor New York Eye and Ear Infirmary, NY, USA

Specialty Uveitis and Ocular Inflammatory Diseases *Dates*2009-2011

Sponsor Casey Eye Institute, OR, USA

Current Diplomat of: MD

Medical Specialty: Ophthalmology *Expiration Date* _____ *MOC* ☐

Subspecialty: Uveitis and Ocular Immunology *Expiration Date* _____ *MOC* ☐

Subspecialty: _____ *Expiration Date* _____ *MOC* ☐

Current Diplomate of: _____

Medical Specialty: _____ *Expiration Date* _____ *MOC* ☐

Subspecialty: _____ *Expiration Date* _____ *MOC* ☐

Name: Amro Ali

Current Licentiates: Limited Permit: P61051 New York State

State / Number NY, Pending *Initial Year Granted* _____ *Expiration Date* _____

State / Number _____ *Initial Year Granted* _____ *Expiration Date* _____

Are you now, or have you ever been, the subject of a professional conduct inquiry, investigation or proceeding?

___ Yes X__ No If yes, please attach a complete explanation and return with this document to your NYMC chairman.

Alpha Omega Alpha Membership

___Yes X__ No If yes, indicate: Associated School: _____

Designation:* _____ *Year of Election:* _____

** i.e., "student", "house officer", "alumnus", or "faculty initiate"*

PROFESSIONAL APPOINTMENTS AND ACTIVITIES: Please see CV for more information

Current and/or Previous Academic Appointments

Title Associate Research Scientist *Department* Obstetrics and Gynecology

Institution New York University Langone Medical Center, *Dates of Service:* 07/01/2012- till present

Title: t Clinical Instructor of Ophthalmology Department Ophthalmology

Institution: Casey Eye Institute Dates of Service 07/01/2009 till present

Title Clinical fellow of Uveitis *Department* Ophthalmology

Institution New York Eye and Ear *Dates of Service* 07/01/2007 to 07/01/2009

Current and/or Previous Hospital Appointments

Title Associate Research Scientist *Department* Obstetrics and Gynecology

Institution New York University Langone Medical Center, *Dates of Service:* 07/01/2012- till present

Title: t Clinical Instructor of Ophthalmology Department Ophthalmology

Institution: Casey Eye Institute Dates of Service 07/01/2009 till present

Title Clinical fellow of Uveitis *Department* Ophthalmology

Institution New York Eye and Ear *Dates of Service* 07/01/2007 to 07/01/2009

Honors/Awards

Active Member of American Academy of Ophthalmology 2004-2005

Professional Activities *(e.g. organized medical/professional societies, etc.)*

Member of American Academy of Ophthalmology, Macular Society, Sleep and Anesthesia Society.

I certify to the best of my knowledge that the information provided above is true.

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SECTION II – RECOMMENDATION OF CHAIR
(To be completed by NYMC Chair)

Name of Faculty/Proposed Faculty Member: Amaro Ali, M.D.

Proposed Faculty Appointment: ☒ Primary ☐ Secondary ☐ Tertiary

In Department of: Ophthalmology

Type of Request: ☒ Appointment at Proposed Title: _____

☐ Promotion

Current Title: Clinical Instructor

Proposed Title: _____

NYMC Faculty Status: ☐ Full-Time ☐ Part-Time ☒ Voluntary

If FT, is tenure being recommended? ☐ *Yes* ☐ *No*

If FT or PT, indicate payroll status (i.e., paid by): ☐ *Affiliate* ☐ *Faculty Practice* ☐ *NYMC*

Assigned Responsibilities:

☐ Teaching
- ☐ Students in
  - ☐ Medical School ☐ Basic Medical Sciences ☐ Health Sciences
- ☐ Residents/Fellows
- ☐ Continuing Medical Education

☑ Research
Type: ☑ Basic Science ☑ Clinical
☐ Other *(please specify)* _____

☐ Patient Care
Practice Setting: ☐ Faculty Practice ☐ Private Practice
☐ Other Setting *(please specify)* _____

Activity Site/Affiliate Designation:

☑ NYMC Basic Sciences Department

☐ Hospital *(please identify)* _____

Division/Section *(please identify)* _____

☐ Community-Based Physician/Primary Care Preceptor

☐ Other *(please specify)* _____

Rev. 07/2015

Name: Amaro, Ali, MD

Signature of Hospital Chair/ Director of Service (if applicable) — *Date*

Signature of Hospital Affiliate Dean (if applicable) — *Date*

Recommended by NYMC Chair — *Date* 12/21/15

Dean's Action:

☐ **Approved as submitted, effective** _____ *(Date)*

Signature of Dean — *Date* APPROVED FEB 4 - 2016

FOR FACULTY RECORDS OFFICE USE ONLY

EMPLID: 1122167 ☒ Created ☐ Modified

Date File Created/Modified: 2-10-16

ABMS: Verified (N/A)

OPMC: (No Match) Match N/A

License Verification in the following State(s): Pending NY

Notes:

OPMC: No results Pending NY License 12/31/15

Rev. 07/2015